NeuroWest Neuropsychology
4001 Lake Otis Parkway, STE 201, Anchorage, AK 99508
P:(907) 615-3477 • F:(907) 615-3478 • NeuroWest.com

Authorization to Release Protected Health Information

Patient: _____ **Date of Birth:** _____

I hereby authorize the use or disclosure of the health care and/or other information as described below. **Revocation:** I understand that authorization may be revoked at any time by written notice to NeuroWest Neuropsychology, LLC, at the address above. I understand revocation is not effective until a notice is received and is not effective regarding disclosures made before the revocation and where authorization was obtained as a condition of insurance coverage. I understand that signing this form is not a requirement for treatment at this practice. **Re-disclosure:** I understand that information released under this authorization may be subject to re-disclosure by the recipient. It may no longer be protected by Federal privacy standards, including HIPAA and the Privacy Act of 1974. If I have questions about the disclosure of my health information, I can contact NeuroWest Neuropsychology, LLC at (907) 615-3477. **Expiration:** This authorization will expire one (1) year from the signature date if nothing is entered here: _____/_____/_____.

By signing below, I authorize NeuroWest Neuropsychology, LLC to (check all that apply):

☐ **Receive** my health information/records from the following persons/entities:

☐ **Disclose** my health information/records to the following persons/entities:

Name: _____

Address: _____

Fax: _____ Phone: _____ Email: _____

Information sent by/to: NeuroWest Neuropsychology, LLC; 4001 Lake Otis Parkway, STE 201, Anchorage, AK 99508-5211; Fax: 907-615-3478; Phone: 907-615-3477; Email: info@neurowest.com

Information Requested:

☐ Neuropsychological/Psychological Evaluation
☐ History & Physical Exam(s)
☐ Discharge Summaries
☐ Medication List (Current)
☐ Laboratory Result(s)
☐ Most Recent Note or Evaluation
☐ Occupational Therapy _____
☐ Physical Therapy _____
☐ Speech-Language _____
☐ Imaging, EEG, and Report(s)

☐ Other: _____

Reason: Care Coordination Neuropsychological Evaluation Other: _____

Sensitive Information: I understand information may include information regarding Psychiatric Treatment, Substance Treatment, STD(s), and/or HIV. Specific Sensitive Information needs to be checked to be disclosed:

☐ Behavioral/Mental Health Treatment ☐ Drug/Alcohol Misuse ☐ HIV/AIDS Information ☐ STD Information

Printed Name of Responsible Party: _____

Relationship to Patient: _____

Signature of Responsible Party: _____ Date: _____

A photocopy of this document is considered to be as valid as the original.